

**Application for Financial Assistance to Partially Fund Towns, Cities, or Mosquito Control District's
Mosquito Control Activities**

**Division of Public Health Services
New Hampshire Department of Health and Human Services**

Application

The application must provide the information outlined below.

1. GENERAL INFORMATION
2. EXPENSES AND AMOUNT REQUESTED
3. FUNDING REQUEST JUSTIFICATION

Application Submittal

Submit a completed application via mail or hand-deliver to the address below before December 1 of the calendar year in which expenses were incurred.

Arboviral Surveillance Coordinator
The Department of Health and Human Services
Division of Public Health Services
29 Hazen Drive
Concord, NH 03301-6504

Award Notification and Acceptance/Denial

NH DHHS will issue a Letter of Award to the recipient town, city, or MCD representative within 30 working days of December 1, indicating funding granted/not granted and reason for the decision.

Communicating with the NH DHHS

Direct questions regarding the application process and awards to Dr. Jason Stull at the NH DHHS at (603) 271-4496 or via email at Jason.Stull@dhhs.state.nh.us.

For Internal Use Only

Date Received: _____

Date PH Threat Declared: _____

Reviewed by (initial & date): _____

Approved by (initial & date): _____

Paid by (initial & date): _____

**Application for Financial Assistance to Partially Fund Towns, Cities, or Mosquito Control
District's Mosquito Control Activities**

GENERAL INFORMATION

Date: ____/____/____

Town/City Name
(Names of all incorporated
towns if MCD):

Name and title of individual
filing the application:

Mailing Address:

Phone Number:

Fax Number:

E-mail:

Authorized Signature: I verify that information contained in this application is accurate, and I am authorized to sign on behalf of the above named town or city.

Signature

Printed Name and Title

For MCDs a representative from each incorporated town/city must sign (attach additional sheets as necessary):

Signature

Printed Name, Title, Town/City

Signature

Printed Name, Title, Town/City

Signature

Printed Name, Title, Town/City

Signature

Printed Name, Title, Town/City

EXPENSES AND AMOUNT REQUESTED

Town/City Name(s): _____

Submission Date: ____/____/____

List below the documented expenses incurred on mosquito control (larvicide and/or adulticide) directed at the public health threat. (Note: a public health threat must be declared by the Commissioner of NH DHHS for the submitting town/city). Expenses eligible for reimbursement include personnel (contracted and employees), mosquito control products, and expenses incurred in application of the control products. Expenses incurred before and/or after the declaration of the public health threat are eligible for reimbursement. Please complete the following summary tables AND attach a detail listing (receipts or invoices where applicable) for all expenses.

Contractual Service For Mosquito Control

Contractor's Name: _____

Address: _____

Type of Service Provided: _____

Expense Category (eligible costs only)	AMOUNT
Personnel	\$
Mosquito Control Products	\$
Mosquito Control Equipment/Application	\$
Other	\$
TOTAL ELIGIBLE EXPENSES	\$
Amount of funding requested (Cannot exceed 25% of total eligible expenses)	\$

Internal Personnel For Mosquito Control

Expense Category (eligible costs only)	AMOUNT
Personnel	\$
Mosquito Control Products	\$
Mosquito Control Equipment/Application	\$
Other	\$
TOTAL ELIGIBLE EXPENSES	\$
Amount of funding requested (Cannot exceed 25% of total eligible expenses)	\$

Prepared by (name, title)

Telephone Number

FUNDING REQUEST JUSTIFICATION

Town/City Name(s): _____

Submission Date: ____/____/____

Provide a justification for the request, including an explanation/discussion why your current resources are insufficient. (You may attach additional pages as needed.)

Note: attach your Mosquito Control Plan if not previously submitted.